

**PATIENT INFORMATION**  
**ALL INFORMATION MUST BE COMPLETED PRIOR TO REGISTRATION**  
**THE BELOW INFORMATION IS TO BE FILLED OUT ON THE PATIENT**  
**BEING SEEN TODAY**

**LAST NAME:**\_\_\_\_\_

**FIRST NAME:**\_\_\_\_\_

**MIDDLE INITIAL:**\_\_\_\_\_

**SUFFIX:**\_\_\_\_\_ (Jr., Sr, 1<sup>st</sup>, 2<sup>nd</sup> etc)

**SS#:**\_\_\_\_\_ **REQUIRED FOR HEAD OF HOUSEHOLD**

**RELATIONSHIP TO HEAD OF HOUSEHOLD:** \_\_\_\_\_

**BIRTH DATE:**\_\_\_\_\_

**NICKNAME:**\_\_\_\_\_

**SEX:**\_\_\_\_\_

**DO YOU OR ONE PARTICIPATE IN THE FREE LUNCH PROGRAM AT SCHOOL:**\_\_\_\_\_

**IF YES, EFFECTIVE WHAT DATE:**\_\_\_\_\_

**BILLING ADDRESS:**

**HOUSE#:**\_\_\_\_\_

**PRE-DIRECTION OF ADDRESS:**\_\_\_\_\_ (NORTH, SOUTH, EAST, WEST)

**NAME OF STREET:**\_\_\_\_\_

**STREET SUFFIX:**\_\_\_\_\_ (AVE, ST, RD ETC)

**POST DIRECTION:**\_\_\_\_\_ (NE, SW ETC)

**APT #:**\_\_\_\_\_

**ZIP CODE:**\_\_\_\_\_

**CITY:**\_\_\_\_\_

**STATE:**\_\_\_\_\_

**HOME ADDRESS:**

**HOUSE#:** \_\_\_\_\_

**PRE-DIRECTION OF ADDRESS:** \_\_\_\_\_ (NORTH, SOUTH, EAST, WEST)

**NAME OF STREET:** \_\_\_\_\_

**STREET SUFFIX:** \_\_\_\_\_ (AVE, ST, RD ETC)

**POST DIRECTION:** \_\_\_\_\_ (NE, SW ETC)

**APT #:** \_\_\_\_\_

**ZIP CODE:** \_\_\_\_\_

**CITY:** \_\_\_\_\_

**STATE:** \_\_\_\_\_

**TELEPHONE NUMBERS:**

**DO NOT LIST A NUMBER BELOW THAT YOU WOULD NOT WANT US TO CALL**

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**HOME:** \_\_\_\_\_

**CELL:** \_\_\_\_\_

**SCHOOL:** \_\_\_\_\_

**WORK:** \_\_\_\_\_

**INCOME DETAILS**

**Does anyone in the family have Medicaid? Yes \_\_\_No\_\_\_**

**Does anyone in the family have Unicare? Yes \_\_\_No\_\_\_**

**Does anyone in the family have Famis/Medallion? Yes \_\_\_No\_\_\_**

**Does anyone in the family have Medicare? Yes \_\_\_No\_\_\_**

**Does anyone in the family have Health Insurance? Yes \_\_\_No\_\_\_**

**If yes to any question above – list below who is covered by what insurance and attach copy of card for verification?**

**Name of covered person(s)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**You are required to show their card for eligibility purposes each time they visit clinic.**

FOR HEALTH DEPARTMENT USE ONLY:

HIPPA:\_\_\_\_\_

TIME IN:\_\_\_\_\_

SCHEDULER:\_\_\_\_\_